Keck Hospital of USC maintains Operating Room policies and protocols to prevent the inadvertent retention of any foreign body during surgery. To address this incident, the hospital undertook several measures, including, but not limited to, convening a multidisciplinary performance improvement group on June 15, 2010 to investigate the factors contributing to the event and identify opportunities to improve care and outcomes in order to prevent subsequent recurrence.

This review identified a lack of clarity within the Surgery Department and associated Operating Room staff regarding the counting of cautery tips as required by the Keck Hospital policy, “Counts: Sharps and Sponges/Instruments.”

### E 000 Initial Comments

The following reflects the findings of the Department of Public Health during an investigation of an entity reported incident.

Intake Number: CA00230939 - Substantiated

Representing the Department of Public Health:

1280.1(c) Health and Safety Code Section 1280

For purposes of this section, “Immediate Jeopardy” means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or likely to cause, serious injury or death to the patient.

### E 347 T22 DIVS CH1 ARTS-70223(b)(2) Surgical Service General Requirements

(b) A committee of the medical staff shall be assigned responsibility for:

(2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body, Procedures shall be approved by the administration and medical staff where such is appropriate.

This Statute is not met as evidenced by:

Based on record review and interview, the facility surgical staff failed to implement their “Counts: Sharps and Sponges/Instruments policy and procedure during Patient A’s surgical procedure. This failure resulted in retention of an electrocautery tip in the patient’s chest cavity and subsequently subjected Patient A to an additional Ongoing
Actions Taken

The following education and interventions were conducted by the group:

1. The involved Operating Room staff were counseled by perioperative management specifically about the importance of counting cautery tips and the need to adhere to the requirements of the policy.

2. An in-service was conducted for the entire Operating Room Staff regarding counting cautery tips and all questions and issues were answered.

3. All new employees receive orientation to and a copy of the "Counts: Sharps and Sponges/Instruments" policy upon hire.

4. Annual performance appraisal and competencies for all employers will now include a review of the "Counts: Sharps and Sponges/Instruments."
During an interview with Employee 3 (Registered Nurse) at the facility on February 25, 2011 at 8:38 a.m., she stated she had failed to conduct the count of the electrocautery tip with Employee 4 (Surgical Technician) during the surgical procedure on Patient A on 2010.

An interview was conducted with Employee 2 (Perioperative Director) on February 25, 2011 at 9:30 a.m. She stated Employee 3 and 4 counted sponges and needles but not the electrocautery tip. According to Employee 2, both Employee 3 and 4 failed to follow the facility's policy and procedure titled, “Counts: Sharps and Sponges/Instruments.”

A review of the facility's policy and procedure titled, "Counts: Sharps and Sponges/Instruments" dated as last revised in February 29, 2008, stipulated "the sharp counts include, but are not
E 347 Continued From page 3

limited to, suture needles, scalpel blades, and cautery tips."

The facility's failure to implement its policy and procedure to prevent retention of an electrocautery tip during a surgical procedure for Patient A is a deficiency that has caused, or likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1.